AT A GLANCE

Racial and Ethnic Approaches to Community Health (REACH) 2010

Addressing Disparities in Health

2005

"We cannot have a healthier and safer America without effectively addressing the marked disparities in health that we see today. Business as usual is not working. CDC is committed to supporting community approaches to eliminating health disparities."

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
COORDINATING CENTER FOR HEALTH PROMOTION

Racial and Ethnic Disparities in Health

Despite great improvements in the overall health of the nation, Americans who are members of racial and ethnic minority groups, including African Americans, American Indians, Alaska Natives, Asian Americans, Hispanics, and Pacific Islanders, are more likely than whites to have poor health and to die prematurely, as the following examples illustrate:

- **Breast and cervical cancer:** Although death rates from breast cancer declined significantly during 1992–1998, they remain higher among black women than among white women. In addition, women of racial and ethnic minorities are less likely than white women to receive Pap tests, which can prevent invasive cervical cancer by detecting precancerous changes in the cervix.
- **Cardiovascular disease:** In 2001, rates of death from diseases of the heart were 30% higher among African Americans than among whites, and death rates from stroke were 41% higher.
- **Diabetes:** Compared with white adults, American Indians and Alaska Natives are 2.3 times, African Americans are 1.6 times, and Hispanics are 1.5 times more likely to have diagnosed diabetes.
- **HIV/AIDS:** Although African Americans and Hispanics represent only 26% of the U.S. population, they account for roughly 82% of pediatric AIDS cases and 69% of both AIDS cases and new HIV infections among U.S. adults. In 2002, they accounted for 62% of all people living with HIV or AIDS in the United States.
- **Immunizations:** Influenza vaccination coverage among adults aged 65 years or older is 69% for whites, 50% for African Americans, and 49% for Hispanics. The gap for pneumococcal vaccination coverage among ethnic groups is even wider: 60% for whites, 37% for African Americans, and 27% for Hispanics.
- **Infant mortality:** Although the 2001 U.S. infant mortality rate of 6.8 deaths per 1,000 live births was the lowest ever recorded, African American, American Indian, and Puerto Rican infants continue to have higher mortality rates than white infants. In 2001, the black-to-white ratio in infant mortality was 2.3.

Because racial and ethnic minority groups are expected to make up an increasingly larger proportion of the U.S. population in coming years, the number of people affected by disparities in health care will only increase without culturally appropriate, community-driven programs to eliminate these disparities. To be successful, these programs need to be based on sound prevention research and supported by new and innovative partnerships among governments, businesses, faith-based organizations, and communities.

CDC's Leadership Role

One of the goals of *Healthy People 2010*, which describes the nation's health objectives for the decade, is to eliminate racial and ethnic disparities in health. The Centers for Disease Control and Prevention (CDC) has a major leadership role in carrying out the goals set forward in this initiative.

REACH 2010

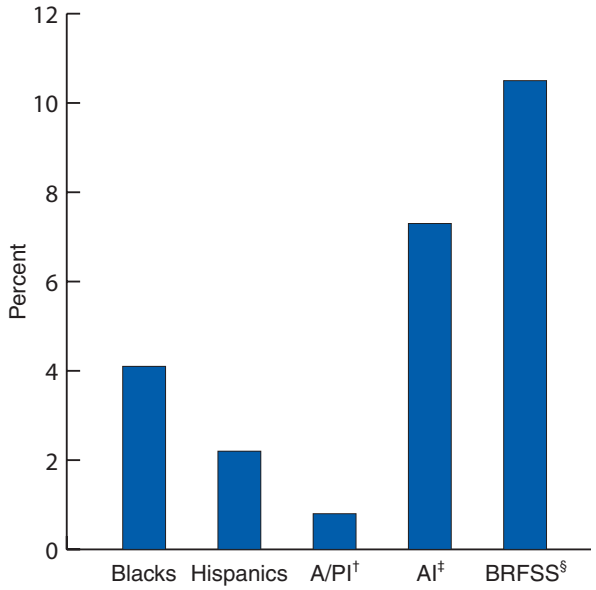
Racial and Ethnic Approaches to Community Health (REACH) 2010 is one of the cornerstones of CDC's efforts to eliminate racial and ethnic disparities in health. Launched in 1999, REACH 2010 is designed to eliminate disparities in the following six priority areas: cardiovascular disease, immunizations, breast and cervical cancer screening and management, diabetes, HIV/AIDS, and infant mortality. The racial and ethnic groups targeted by REACH 2010 are African Americans, American Indians, Alaska Natives, Asian Americans, Hispanics, and Pacific Islanders.

In fiscal year 2005, CDC received $34.5 million for this program. In fiscal year 2004, CDC supported 40 REACH 2010 projects, four of which serve the elderly. CDC also supported a new emphasis on American Indian and Alaska Native communities by continuing to fund core capacity building projects in Albuquerque, NM; Oklahoma City and Talihina, OK; Anchorage, AK; and Nashville, TN.

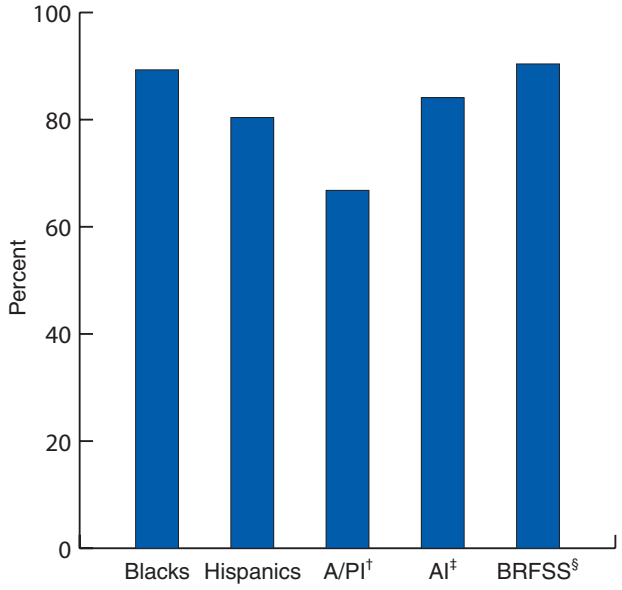
REACH 2010 supports community coalitions in designing, implementing, and evaluating community-driven strategies to eliminate health disparities. Each coalition comprises a community-based organization and three other organizations, of which at least one is either a local or state health department or a university or research organization. REACH 2010 grantees are using local data to implement interventions that address one or more of the six priority areas and target one or more racial and ethnic groups. The activities of these community coalitions include continuing education on disease prevention for health care providers, health education and health promotion programs that use lay health workers to reach community members, and health communications campaigns.

REACH 2010 Risk Factor Survey* Findings

People Who Knew the Signs and Symptoms of Heart Attack, by Race/Ethnicity



Women Who Had a Pap Test in the Last 3 Years, by Race/Ethnicity



* Conducted during 2001–2002 in 21 communities.
† Asians/Pacific Islanders.
‡ American Indians.
§ For comparison, data from the 2001 Behavioral Risk Factor Surveillance System from 50 states and the District of Columbia.

In 2004, REACH 2010 projects were promoted in two journals. In August, CDC's *Morbidity and Mortality Weekly Report* published "Health Status of Cambodians and Vietnamese—Selected Communities, United States, 2001–2002" (Vol. 53, No. 33) and "REACH 2010 Surveillance for Health Status in Minority Communities—United States, 2001–2002" (*Surveillance Summaries*, Vol. 53, SS-6). In addition, the summer supplement of *Ethnicity & Disease* featured 20 articles about the REACH 2010 program and its projects (Vol. 14, No. 3, Supplement 1). Project grantees contributed most of the articles, which described local projects and action plans, discussed the importance of community focus groups, and documented changes in the targeted communities. One article presented major findings from the REACH 2010 Risk Factor Survey conducted in 21 communities, and CDC provided a guest editorial.

Working With Partners

Several agencies and offices within the U.S. Department of Health and Human Services (HHS) have played critical roles in planning, coordinating, and supporting the REACH 2010 program. In a major show of support, the National Center on Minority Health and Health Disparities at the National Institutes of Health contributes $5 million annually to support REACH 2010 projects. Other partners within HHS include the Office of the Secretary, the Health Resources and Services Administration, and the Administration on Aging.

Evaluating Communities in Action

Data from the REACH 2010 Risk Factor Survey provide important information on the health status of residents in REACH 2010 communities that have programs focused on breast and cervical cancer prevention, cardiovascular health, and diabetes. Communities will use this information to evaluate widespread changes in risk-reduction behaviors and reductions in health disparities among their members. Positive behavior changes that have reduced health risks in REACH 2010 communities to date include increases in the percentages of community members receiving mammograms, Pap smears, and cholesterol and glycated hemoglobin screenings. These changes have helped to reduce disparities in cholesterol and diabetes screenings.

A critical part of the REACH 2010 strategy is to test the effectiveness of programs in improving the health of racial and ethnic minority populations. The following are examples of REACH 2010 programs:

New Mexico: Targeting Breast and Cervical Cancer Among American Indian Women

The Partners in Tribal Community Capacity Building Program, which is supported by the Albuquerque Area Indian Health Board (AAIHB), is developing a culturally appropriate plan to address local health concerns in American Indian communities. A key focus is improving the low survival rates from breast and cervical cancer among American Indian women.

As part of a pilot program in one tribe, health officials developed a local public health task force, a cancer awareness campaign, and culturally appropriate mammography services. They also are creating a community-specific health promotion video on breast and cervical cancer. In addition, the AAIHB distributed a curriculum for public health skills training to seven southwestern tribes.

Massachusetts: Targeting Cardiovascular Disease And Diabetes Among Cambodians

Cambodian Community Health 2010, sponsored by the Lowell Community Health Center (LCHC), develops interventions that target the Cambodian community and its leaders, health care providers, and public health researchers. As part of these efforts, community health educators teach people how to decrease risks and enhance protective behaviors associated with diabetes and cardiovascular disease. Educational classes are held in temples, churches, community agencies, and places where people learn English. Tours of local hospitals, police stations, and health centers increase comfort and familiarity with these settings. Other strategies include organized walks, weekly Tai Chi classes, medical interpreter services, and nutritional education.

Since LCHC's Metta Health Center opened in 2000, the number of Cambodians accessing heath care at LCHC has increased from 1,070 in 2000 to 3,080 in 2004. During this time, the number of patients with diagnosed diabetes grew 89%, from 23 in 2001 to 212 in 2004. Of patients who had attended educational workshops and peer support groups, 50% reported behavioral changes such as limiting salt or sugar intake and controlling bad eating habits.

Massachusetts: Targeting Diabetes Among Latinos

The REACH 2010 Latino Health Project is working to address the high prevalence of diabetes among Puerto Rican and Dominican residents in Lawrence. Interventions include community strategies that teach people how to control the disease and environmental strategies that improve access to primary care at the Greater Lawrence Family Health Center. Culturally tailored prevention strategies include media outreach, church involvement, exercise and educational programs, and empowerment groups. Preliminary data for Latino residents with diabetes in Lawrence indicate dramatic improvements in control of blood glucose and high blood pressure during 2001–2003. Several recommended measures of diabetes care also improved. For example, the percentage of participants whose smoking status was reviewed by a doctor increased from 27% to 66.3%.

Alabama: Targeting Cancer Screening Disparities Among African American Women

The University of Alabama at Birmingham Breast and Cervical Cancer Coalition works to reduce disparities in breast and cervical cancer screening and outcomes between African American and white women in selected counties. The coalition designed a comprehensive program to address barriers at multiple levels that prevent women from being screened appropriately. Professional and lay health advisors disseminate tailored information to women to support, encourage, and help them obtain screening services and navigate the health care system. As a result, disparities in mammography screening were reduced from 15% in 1998 to 2% in 2003 in Macon County.

Future Directions

Working with local communities, CDC has made substantial strides in reducing racial and ethnic health disparities. The REACH 2010 program is developing a dissemination plan to share lessons learned from REACH 2010 communities to help others develop and implement culturally appropriate prevention and intervention strategies. REACH 2010 also will expand policy initiatives that target environmental change, document the impact of cultural competency in coalitions, and build program capacity to include social determinants research. CDC and REACH 2010 will continue to help communities collect local data and evaluate community strategies to reduce or eliminate health disparities.

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